Bundle Quality, Safety & Experience Assurance Committee 13 August 2020

4.2 Listening & Learning Sub-Committee

Presenter: Maria Battle/Louise O'Connor

Item 4.2 L&L Exception Report from the July Sub-Committee Meeting

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Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Listening and Learning Sub-Committee
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Maria Battle, Hywel Dda University Health Board (HDdUHB) Chair
Cyfnod Adrodd: Reporting Period:	2nd July 2020

Materion Ansawdd, Diogelwch a Phrofiad: Quality, Safety & Experience Matters:

The Listening and Learning Sub-Committee reviewed 7 individual cases, across the spectrum of redress; complaints; claims; serious incidents and public services ombudsman reviews. The following themes were noted for further action:

Management of inpatient falls

The theme of avoidable in-patient falls was discussed within serious incident, claims and redress cases. The Sub-Committee received a draft service improvement corporate action plan and agreed that a corporate wide approach is required. The Sub-Committee further agreed to receive quarterly updates on falls cases and progress with falls reduction work, rather than individual cases due to the consistency of issues in all of the cases. The cases reviewed also raised concerns associated with avoidable Hospital Acquired Thrombosis (HAT). This specific issue has been referred to the HAT Task and Finish Group for further review and action.

Missed/Delayed Diagnosis of Fractures

The issue of missed/delayed diagnosis of fractures has also been a consistent theme raised in concerns, which frequently results in claims or redress claims. This is due to a patient suffering pain, loss of amenity or in some cases requiring additional treatments, with a number of explanations or root causes identified for the delay in diagnosis.

Previously, the Sub-Committee reported that a recurring theme in many cases related to the lack of follow up and action taken by the referring clinician of test results. A Task and Finish Group has been established to consider an improvement initiative, led by the Deputy Medical Director for Quality and Safety.

Following discussions, it was proposed that a review of the pathway for diagnosis and management of fractures should be considered (particularly in relation to bony wrist injuries), which will form part of the Task and Finish Group's review of results, referred to above.

Delayed Diagnosis of Cauda Equina

The Sub-Committee noted that a review of the spinal pathway is being undertaken and that this matter has already being considered under the Quality, Safety and Experience Sub-Committee governance arrangements.

Delay in Diagnosis of Pulmonary Embolus

The Sub-Committee agreed to defer this case for further discussion surrounding the learning and assurance action plan.

Dental Services - Wrong Tooth Extraction

The Sub-Committee approved the learning in this case, given that further scrutiny will be required via the National Safety Standards for Invasive Procedures (NatSSIP) process.

Discharge Arrangements

The Sub-Committee agreed to defer this case in order to receive further evidence on learning assurance. Concerns regarding perceived unsafe discharges were noted and will be subject to further review by monitoring of the concerns and patient experience feedback data.

Public Services Ombudsman for Wales

The Sub-Committee noted the review finding emphasising that the Health Board should have been aware of the patient's vulnerability to infection, when managing their shoulder injury. The RRAILS Group has been tasked to consider whether the Sepsis guidance requires further review in light of the Ombudsman's findings.

A review of the process for recording attendances of clinicians at training events and case reviews, together with the associated topics, will be undertaken by the Assurance Safety and Improvement Team.

Risgiau:
Risks (include Reference to Risk Register reference):

The Sub-Committee requested that the high incidence of avoidable inpatient falls be escalated to the Quality, Safety and Experience Assurance Committee.

Gwella Ansawdd:
Quality Improvement:

As noted above, the identified actions for quality improvement have been identified as:

- Reduction in avoidable inpatient falls
- Follow up and action of test results
- Reduction in the delayed diagnosis of fractures

Argymhelliad:
Recommendation:

- The Quality, Safety and Experience Assurance Committee is asked to discuss whether the actions taken by the Sub-Committee to mitigate the risks are adequate.

Dyddiad y Cyfarfod Pwyllgor Nesaf:
Date of Next Sub- Committee Meeting:

5th August 2020

Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Listening and Learning Sub-Committee
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Paul Newman (in the absence of Maria Battle, Health Board Chair)
Cyfnod Adrodd: Reporting Period:	5th August 2020

Materion Ansawdd, Diogelwch a Phrofiad: Quality, Safety & Experience Matters:

The Sub-Committee reviewed 11 individual cases, across the spectrum of redress; complaints; claims; serious incidents and public services ombudsman reviews. The following are the main issues discussed and noted for further action:

Missed/delayed diagnosis of fractures

Further to previous Sub-Committee reports on the diagnosis and management of fractures, Members agreed that a Task and Finish Group should be established under the Enabling Quality Improvement in Practice (EQIiP) Programme. An initial scoping exercise will be undertaken to inform this work, overseen by the Quality Improvement Team.

Additional issues considered at the meeting concerned the radiology 'red flag' process, including how the red flag is communicated to the referrer; and the follow up and action in relation to this. An audit/review of this will be incorporated into the scoping exercise.

Orthopaedic Surgery – ACL repair (ligament injury repair)

The Sub-Committee received the proposed actions to be undertaken by the Directorate in response to a claim. Members also noted that the Welsh Risk Pool has deferred approval of the learning in this case, subject to further assurance being provided. Proposed actions included the review and reflection of the case by soft tissue knee specialists across the Health Board; to undertake a patient service satisfaction survey; review of the protocol for discharge following ACL repair procedures; ensuring post-operative support equipment is ready for purpose; and training for the clinical staff involved. Further assurance has been requested for review at the next Sub-Committee meeting.

Use of WHO (World Health Organisation) Surgical Checklist

The findings of the incident investigation determined that the WHO surgical checklist had not been correctly followed. Actions, including a rolling audit were noted and a further review of the action plan progress to be scheduled for later in the year and reported through Quality, Safety and Experience Assurance processes.

Retained Swab

The findings of the incident investigation and associated action plan were approved. The Sub-Committee appreciated the timeliness of the investigation report and the use of the 'just culture' guide.

Public Services Ombudsman for Wales

The Sub-Committee noted four Ombudsman final reports which have been received since the previous Sub-Committee meeting.

1) Delay in Diagnosis of Pulmonary Embolus – the case found a delay in a referral to the respiratory teams. The progress with the action plan was noted. A review of the concerns investigation process in this case is being undertaken at the request of the Chief Executive.
2) Escalation of foetal scan findings - whilst the Ombudsman found no shortcomings in the patient's care and management, he did find that an appropriate scan referral to an obstetrician should have been carried out earlier. The Sub-Committee approved the learning plan in this case.
3) Referral process to specialist services – the case found there was a delay in a referral being undertaken to vascular services, whilst no significant clinical concerns have been identified the Health Board has been invited to undertake a review of its process for referrals to specialist services; and also a review of the process of GP referrals to vascular services or services not provided by the Health Board. The Sub-Committee noted the work being progressed by the Quality, Safety and Experience Assurance Committee on specialist services.
4) Management of Head and Neck Pain presentation at the Emergency Department - whilst the Ombudsman found that the advice and treatment the patient received was satisfactory, it was found that a computed tomography (CT) scan should have been requested earlier to explore other potential causes for the symptoms. It was recommended that the Health Board review its policies on the management of patients who present to the emergency department (ED) with sudden onset head and neck pain, and for patients who return to the ED within a short time span with worsening symptoms, and consider whether these patients should be reviewed by a senior clinician before being discharged. The Action Plan for this case will be reviewed at the next Sub-Committee meeting.

Risgiau:
Risks (include Reference to Risk Register reference):

Actions are currently being considered to mitigate the risks of a lack of a) follow up and action of test results b) diagnosis and management of fractures, in the interim period, whilst the quality improvement work is being undertaken.

Gwella Ansawdd:
Quality Improvement:

As noted above, the identified actions for quality improvement have been identified as:

- Follow up and action of test results
- Reduction in the delayed diagnosis of fractures

• Review and audit of the WHO surgical checklist • Referral process and management of patients requiring specialist services • Process for management of patients presenting with Head and Neck Pain to the Emergency Department
Argymhelliad: **Recommendation:**
• The Quality, Safety and Experience Assurance Committee is asked to discuss whether the assurance and actions taken by the Sub-Committee to mitigate the risks are adequate.
Dyddiad y Cyfarfod Pwyllgor Nesaf: **Date of Next Sub- Committee Meeting:**
2nd September 2020